SICKNESS CLAIM FORM

FOR ASSOCIATE USE ONLY:

☐ **Send the insured's check to the associate for delivery.** **Writing No.:** _____ **Name:**_____	**Address:** _____ _____

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime, and subjects such person to criminal and civil penalties.

FILING CLAIM FOR:

☐ Sickness ☐ Cancer ☐ Pregnancy ☐ Deceased Date Deceased: ___/___/___

Cancer Policy Number	**Short-Term Disability** Policy Number	**Hospital Indemnity** Policy Number	**Hospital Intensive Care** Policy Number	**Specified Health Event** Policy Number

SECTION A: PATIENT/POLICYHOLDER INFORMATION: Please sign claim form at the bottom of page 2.

PATIENT'S INFORMATION			POLICYHOLDER'S INFORMATION		
LAST FIRST INITIAL			LAST FIRST INITIAL		
☐ MALE ☐ FEMALE ☐ SINGLE ☐ MARRIED ☐ OTHER	BIRTHDATE		ADDRESS CHECK IF NEW ADDRESS ☐		
RELATIONSHIP: ☐ SELF ☐ SPOUSE ☐ DEPENDENT CHECK IF CHILD IS FULL-TIME STUDENT ☐			CITY	STATE	ZIP
SOCIAL SECURITY NUMBER (optional)	PHONE NUMBER		SOCIAL SECURITY NUMBER (optional)		BIRTHDATE

SECTION B: PHYSICIAN'S STATEMENT: Please print. Must be completed by physician or physician's staff.

PHYSICIAN'S NAME	ADDRESS	PHONE NUMBER

DATES OF SERVICE	DIAGNOSIS CODE ICD	DIAGNOSIS DESCRIPTION	PROCEDURE CODE	PROCEDURE DESCRIPTION	ACTUAL CHARGES

1. Is this condition covered by Medicaid/state aid? ☐ Yes ☐ No
2. Symptoms first occurred on: _____/_____/_____ Patient first consulted you for this condition on: _____/_____/_____
3. Has any other physician ever treated the patient for this condition? ☐ Yes ☐ No

If yes, Physician's name: _____ Phone number: _____

4. If pregnant, date of delivery: _____/_____/_____ ☐ Vaginal ☐ Cesarean If not delivered, expected delivery date: _____/_____/_____
5. Was patient hospitalized? ☐ Yes ☐ No If yes: Admission: _____/_____/_____ Discharge: _____/_____/_____

Hospital Name: _____ City: _____ State: _____

ATTENTION PHYSICIAN: If patient is disabled, please ALSO complete SECTION C ON PAGE 2 OF THIS FORM.

PHYSICIAN'S SIGNATURE _____ DATE _____ TAX ID NUMBER _____

American Family Life Assurance Company of Columbus (AFLAC)
Attention: Claims Department
Worldwide Headquarters: 1932 Wynnton Road, Columbus, GA 31999
For information or help filing your claim, please call toll-free 1-800-99-AFLAC (1-800-992-3522) or visit our Web site at www.aflac.com
Toll-free fax number 1-877-44-AFLAC (1-877-442-3522)

SICKNESS CLAIM FORM - DISABILITY SECTION

Failure to complete this form in its entirety may result in a delay in processing this claim.
Complete only if claiming disability benefits under an AFLAC policy.

SECTION C: PHYSICIAN'S DISABILITY STATEMENT

♦ **Please print. Must be completed by physician or physician's staff.**

1. First date of disability: _____/_____/_____ Last date of treatment: _____/_____/_____
2. Date released to return to work: _____/_____/_____ If not released, next appointment date: _____/_____/_____
3. Is patient: ☐ ambulatory? ☐ bed-confined? ☐ house-confined? ☐ hospital-confined?
4. If not employed, or employed less than 30 hours per week, which **A**ctivities of **D**aily **L**iving (**ADLs)** is patient unable to perform?

Check all that apply: ☐ Continence ☐ Transferring ☐ Dressing ☐ Toileting ☐ Eating ☐ Bathing

5. Has patient been treated for this condition within the last 12 months? ☐ Yes ☐ No If yes, Date of treatment: _____/_____/_____

PHYSICIAN'S SIGNATURE | DATE | TAX ID NUMBER

SECTION D: EMPLOYER'S DISABILITY STATEMENT

♦ **Please print. To be completed by Employer if filing for disability.**
♦ **If self-employed complete this section and submit a copy of business license and previous year's tax return**

EMPLOYER'S NAME	ADDRESS	PHONE NUMBER

WORK STATUS

1. Is the employee currently earning at least 80% of their salary prior to disability? ☐ Yes ☐ No
2. Prior to this disability, number of hours worked per week: _____ Annual Base Salary: $ _____
3. Is the person still employed? ☐ Yes ☐ No If no, date left employment: _____/_____/_____
4. First date employee unable to work: _____/_____/_____ Last date employee unable to work: _____/_____/_____
5. Is employee currently working? ☐ Yes ☐ No If yes, is employee working ☐ full-time? ☐ part-time? ☐ light duty?
6. Date to return to Full Time Duty: _____/_____/_____

PREMIUM/TAX INFORMATION

Please note:
The employer is required to report disability benefits paid on pre-tax plans on its Form 941 and the employee's Form W-2.

1. Does the employee pay disability premiums with pre-tax dollars? ☐ Yes ☐ No
2. Does employer pay a portion of the disability premium for the employee? ☐ Yes ☐ No If yes, what percent? _____%
3. Employee is: (Check all that apply) ☐ exempt from Social Security ☐ exempt from Medicare ☐ subject to RRTA

EMPLOYER'S SIGNATURE | TITLE | DATE

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime, and subjects such person to criminal and civil penalties.

CLAIMANT SIGNATURE | **FAMILY RELATIONSHIP, IF NOT POLICYHOLDER** | **DATE**

American Family Life Assurance Company of Columbus (AFLAC)
Attention: Claims Department
Worldwide Headquarters: 1932 Wynnton Road, Columbus, GA 31999
For information or help filing your claim, please call toll-free 1-800-99-AFLAC (1-800-992-3522) or visit our Web site at www.aflac.com
Toll-free fax number 1-877-44-AFLAC (1-877-442-3522)

Policy #: | | | | | | | | |

AU

AUTHORIZATION TO OBTAIN INFORMATION

I authorize the following to give information (as defined below) to American Family Life Assurance Company of Columbus (AFLAC) or any person or entity acting on its part: any medical professional, medical care institution, insurer (including AFLAC, with respect to other AFLAC coverages), reinsurer, government agency (including departments of public safety and motor vehicle departments), consumer reporting agency or employer. "Information" means facts or opinions relating to my past, present, or future physical or mental health or condition (excluding psychotherapy notes), employment, other insurance coverage, or any other non-medical facts that AFLAC deems appropriate to evaluate claims for benefits during the time this authorization is valid. I understand that any disclosure of information to AFLAC for the purpose of evaluating claims for benefits for coverage other than health plan coverage means the information may no longer be protected by federal privacy regulations. I further understand, however, that such information may be re-disclosed only in accordance with other applicable laws or regulations.

I understand that this information will be used by AFLAC to evaluate claims for benefits.

I understand that I may revoke this authorization at any time, except to the extent that (1) AFLAC has taken action in reliance on this authorization, or (2) other law provides AFLAC with the right to contest a claim under the policy or the policy itself. My revocation must be submitted in writing to AFLAC, Claims Department, Worldwide Headquarters, 1932 Wynnton Road, Columbus, GA 31999.

Unless otherwise revoked, I agree that this authorization will expire two years from the date indicated below.

I agree that a copy of this authorization is as valid as the original.

_____ _____

Signature Date Printed Name

Individual/Guardian/Personal Representative

_____

Printed Name

If this authorization has been signed by a personal representative on behalf of an individual, his/her authority to act on behalf of the individual must be set forth here:

Policy #: | | | | | | | | |

AU

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I agree that a copy of this authorization is as valid as the original.

Signature Date Printed Name

Individual/Guardian/Personal Representative

Printed Name

If this authorization has been signed by a personal representative on behalf of an individual, his/her authority to act on behalf of the individual must be set forth here:

RETAIN THIS COPY FOR YOUR RECORDS